

PATIENT LAST NAME _____ First Name _____ Date _____
Date of Birth _____ Age _____ Sex Male Female _____
Social Security Number (if adult): _____ Email _____
Address _____ City _____ Zip _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Occupation (or) School and Grade: _____
How did you hear about us? _____

Patients Physician _____ Phone No _____
Patient's Dentist _____ Phone No _____
Address _____
Emergency Contact _____ Phone No _____

Marital Status of Parents or Self: S M D W

GUARDIAN 1. NAME _____ Relationship: _____ Social Security No. _____
Employer _____ Occupation _____
Employer's Address _____ Employer's Phone _____)

GUARDIAN 2. NAME _____ Relationship: _____ Social Security No. _____
Employer _____ Occupation _____
Employer's Address _____ Employer's Phone _____

PERSON RESPONSIBLE FOR ACCOUNT _____ Relationship _____
Social Security No. _____ Birthdate _____ Email _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Insurance Co _____ Group No _____ Insurance Co Phone _____
Insurance Co Address _____ City _____ State _____ Zip _____

PERSONAL INTERESTS

Does patient play any sports? (Please list) _____
Does patient play any musical instruments? _____
Other hobbies or interests? _____ Pets? _____

Printed Patient or Guardian Name (if minor)

Signature of Guardian or Parent (if minor)

Date